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ABSTRACT

The cost analysis project report is directed towards persons in policy-making and administrative positions at the national, State, and direct service agency levels. Its purpose was to survey the literature and records to identify costs of homemaker-home health aide services and comparative costs of alternative forms of services. Part 1 includes summary of cost data, conclusions, and recommendations. The data were found to support the thesis that homemaker-home health aide services, when provided alone or as one of an array of in-home services, are usually less costly than any of the out-of-home alternatives. Part 2 describes the project's background and design. Part 3 presents the survey results. Clusters, based on need factors, differentiated among the costs of services: need for environmental service, need for personal service, and need for professional service. Cluster 1 specifies professional treatment, Cluster 2 requires personal service only, and Cluster 3 requires environmental services only. A chart illustrates the comparisons between the three clusters and appropriate service delivery alternatives. Cost analyses are conducted in terms of the factors. A 10-page annotated bibliography, a 4-page supplementary bibliography, and a list of addresses of sources are included. (JB)

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COSTS OF HOMEMAKER-HOME HEALTH AIDE AND ALTERNATIVE FORMS OF SERVICE

A Survey of the Literature

Nancy Robinson
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Florence Moore

Published by the National Council for
Homemaker-Home Health Aide Services, Inc.
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PREFACE

The cost of many human services has risen sharply during the last several years due to a variety of factors. This increase in costs, especially in out-of-home services, inevitably focuses attention more strongly on in-home services, including homemaker-home health aide service, a basic service for helping individuals of all ages to remain in their own homes.

Data on the costs of homemaker-home health aide services in comparison with costs of alternative types of care are badly needed. Through a generous grant from the American Association of Retired Persons and the National Retired Teachers Association, the National Council for Homemaker-Home Health Aide Services was able to undertake a survey of the literature on costs of homemaker-home health aide services and alternative types of care. This review was considered basic to further research on costs of homemaker-home health aide services.

The National Council is also indebted to those persons who guided the project, undertook the necessary reading and analysis, and prepared this report.

Richard D. Rife, president of the Capital Blue Cross, Harrisburg, Pennsylvania, a member of the National Council's Board of Directors, and chairman of the Uniform Accounting and Reporting Committee, guided the project.

Dr. Nancy Robinson was responsible for the analysis and reporting of the basic data. Subsequent to assuming this assignment, Dr. Robinson became the director of the National Council's agency approval project.

Dr. Eugene Shinn, associate professor, Hunter College School of Social Work, and research consultant to the National Council, helped to plan the project and provided substantive assistance during the final drafts.

Miss Esther Adam, now a research assistant with the Hudson Institute, gathered many of the source materials and drafted the annotated and supplementary bibliographies.

Mrs. Patricia Soyka, publications consultant to the National Council, gave counsel on wording of the manuscript and edited the last draft.

Mrs. Clara Avallone and Miss Ruth Gregory did the secretarial work for the project.

Mrs. Florence Moore, executive director of the National Council, carried overall responsibility for the project from its inception through the preparation of the final report.

We believe that the report will be useful to many individuals in policy-making, as well as administrative, positions at national, state, and direct service agency levels. The National Council for Homemaker-Home Health Aide Services looks forward to finding the ways and means of undertaking the additional studies discussed in the Recommendations section of the report.

Ellen Winston
President

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GLOSSARY

Homemaker-home health aide service.--Homemaker-home health aide service helps families to remain together in their own homes when a health and/or social problem occurs or to return to their own homes after specialized care. The homemaker-home health aide carries out assigned tasks in the family's place of residence, working under the supervision of a professional person who also assesses the need for the service and implements the plan of care.

Homemaker-home health aide.--A trained, supervised paraprofessional working as a member of a health and/or social services team who carries out assigned tasks in the home in the area of personal and environmental services.

Personal services.--Bathing, toileting, feeding; assistance with ambulation; assistance with prescribed exercises and medication; physical supervision, as of children at play or of elderly persons whose movements are unsure; teaching and emotional support tasks such as showing a newly blinded person how to handle daily living tasks, showing a mother ways to cope with a disabled child, giving help with homework, helping a person handle crises of loss of physical abilities or hospitalization or death of a family member.

Environmental services.--Housecleaning; cooking; shopping for food; and other home management tasks; and the services supplementary to homemaker-home health aide services.

Services supplementary to homemaker-home health aide services.--All of the other than homemaker-home health aide services which are in-home services, but are not professionally oriented, although they function under minimal professional supervision. Among the supplementary services are telephone reassurance, meal service, friendly visitors, transportation, shopping, escort service, household repair service, and barbering and hairdressing.

Intensity of service.--Hours of service in a day and the number of days per week the service is provided.

Duration of service.--Weeks or months comprising the length of time service is provided to a given person or family.

Complexity of service.--The range of (1) homemaker-home health aide tasks, and (2) related health and welfare services.

I

SUMMARY OF COST DATA, CONCLUSIONS, AND RECOMMENDATIONS

Summary of cost data

A summary of cost figures quoted in the text for homemaker-home health aide and for the major alternative forms of service follows. Generally, the most recent figures obtained were selected.

Homemaker-home health aide services.--In 1971-72, the average cost per hour, per family unit, was $3.98, the median cost $3.79, within a range of $2.09 to $7.50. The average cost per case, per year, was $467.79. These figures from the National Council for Homemaker-Home Health Aide Services, Inc., were compiled from data made available by its approved programs.

Hospital revenue.--1973 figures based on the average revenue per day, per patient, in short-stay hospitals amounted to $95 to $100. These statistics were reported in Prism: The Socioeconomic Magazine of the American Medical Association.

Extended care facilities.--For 1972, the average cost per day, per patient, was $13 - $19, as reported by the American Hospital Association.

Nursing homes.--In 1972, for elderly persons in Maryland, the average cost per day, per patient, was $39 for chronic care, $32 for skilled care, and $24 for intermediate care, as reported by the Governor's Commission on Nursing Homes.

Residential treatment centers and other institutions for children.--For fiscal 1972-73, reimbursement from New York State and City to voluntary institutions averaged $30 per day, per child, or $915 per month, per child, as reported by the New York City Bureau of Child Welfare.

Foster home care for children.--For 1973, reimbursement from New York State and City to voluntary institutions averaged $12 per day, per child, or $360 per month, per child, as reported by the New York City Bureau of Child Welfare.

Conclusions

1) Considerable data on the cost of homemaker-home health aide services and alternative forms of care are available. More data are available for homemaker-home health aide services for the aging and relating to the health field than are available for children or relating to the social services field.

2) Much of the cost data from within the homemaker-home health aide field are not fully comparable, nor are data about the costs of alternative forms of service fully comparable with homemaker-home health aide service data.

3) Cost studies by homemaker-home health aide agencies usually are not addressed to differing intensity, duration, and complexity of the service provided. While it is obvious that the supervision needed by the homemaker-home health aide and the tasks carried out within a home vary according to the needs and strengths of the individuals and families receiving services, little has been written which differentiates need according to diagnosis or which includes an assessment of the strengths as well as of the problems of an individual. As a result, there is no differentiation as to costs of the tasks necessary to provide supports lacking in given situations.

4) A uniform system of recording and reporting data, both fiscal and statistical, is lacking for the homemaker-home health aide field, as it is throughout most of the health and social service fields.

5) Funding is more readily available for out-of-home services than for in-home services.

6) Where the needs of an entire family must be met, homemaker-home health aide service, alone or as one of an array of services, is more likely to meet them than are alternate forms of service. The alternate forms of service - hospitals, nursing homes, or foster care - provide almost no service to other members of the family. For instance, cost of hospital care for a mother following surgery does not include any in-home care for supervision of her children.

7) Out-of-home care, especially in foster homes and nursing homes, tends to become long-term care, whereas in-home care can more often and more quickly return an individual and a family to independent functioning.

8) Medicare and other third-party payers which place unduly restrictive conditions on the giving of service by paraprofessionals make it unnecessarily difficult - sometimes impossible - to provide the best service at the lowest cost. Such restrictions often result in the following painful situations:

a) A person who could be cared for at home may be forced into an institution in order to receive the services he needs.

b) Delivery of service is fragmented when two paraprofessionals are required to assist a family, one carrying out personal care tasks and paid from one "tax pocket", while the other carries out environmental tasks and is paid from another "tax pocket", when all the needed services could be handled readily by one homemaker-home health aide, with far less cost and confusion.

c) Too frequently, the person who is genuinely in need of services may have to do without them altogether.

9) The available data support the thesis that homemaker-home health aide services, when provided alone or as one of an array of in-home services, are usually less costly than any of the out-of-home alternatives.

Recommendations

1) A uniform recording and reporting system should be developed for agencies delivering homemaker-home health aide services, so that comparable data, both fiscal and statistical, may be made available on a cumulative basis for the individual agency or for many agencies, locally, and at state, regional, and national levels.

2) A uniform reporting system should be developed in such a way that on a case-by-case basis the cost data are related to the needs of the individual and/or family being served, and to the patterns of service provided. Patterns of service include the intensity, duration, and complexity of services provided.

   Each service provided by the agency should be costed out separately, differentiating costs of homemaker-home health aide services from those of supplementary services such as meals-on-wheels, or chore service, and from professional treatment services such as social work, nursing, and physical therapy.

   Within each service the various components which make up the total cost, such as administration, training, and capital costs should be broken out. Inclusions and exclusions should be stated.

3) Research projects exploring the related matters of patterns of need, tasks involved in meeting need, costs, and effects of care for individuals and families grouped according to problem situations, to age groups, and to living arrangements are very much needed. Case costing according to classification of specific needs and specific services to meet those needs would be much more useful in policy and planning than the present methods of using per hour, per visit, or per diem costs broadly defined by setting. The itemizing of the service to be rendered in different situations should be the focus of systematic research.

4) In order to obtain statistics on need-service-cost patterns in the immediate future, a study might be undertaken using data from a number of the National Council's approved programs which are using the International Classification of Diseases. The International Classification of Diseases provides a beginning framework for categorizing needs and problem situations by which patterns of service and cost may be reflected. The use of other ways of categorizing needs for service should be explored.

5) The cost of homemaker-home health aide services should be compared

with alternative forms of care on a case basis, in order to account for the duration and volume of service.

6) Further study, both cross-sectionally and longitudinally based, should be undertaken of the comparative impact, both positive and negative, on people, of the various forms of in-home and out-of-home modes of service delivery for children, for the elderly, and for other age groups.

7) It is necessary to interpret to policymakers the need for funding mechanisms which do not fragment the service. For example, for maximum economic and human benefits the services the homemaker-home health aide can provide should be covered in a manner flexible enough to include personal and environmental services to meet the needs arising from health problems.

8) It is necessary to interpret to policymakers the need for careful examination of requirements based on prior conditions to provision of service, so that they do not defeat the very economies they are developed to achieve. For example, hospitalization should not be a required prior condition before third-party payers will reimburse in-home health care.

II

THE BACKGROUND AND DESIGN OF THE PROJECT

The purpose of the cost analysis project was to survey existing literature and records to identify the known and unknown about costs of homemaker-home health aide services and comparative costs of alternative forms of service. Summarization of currently available cost data, despite any limitations, was believed to offer an interim basis for making interpretations and guiding policy decisions as well as for identifying areas requiring further research on costs and benefits in the homemaker-home health aide field.

The focus of the survey

Decisions in the health and welfare fields are often made on the basis of cost factors. Unfortunately, because factors contributing to cost are sometimes complex and obscure, decisions are too often founded on unsubstantiated beliefs about costs and benefits. There is a great need in the homemaker-home health aide field for objective facts and for statistics that can be used to support better administrative decision-making and formulation of policy. A survey of existing records on costs for homemaker-home health aide services was the natural place to begin. The opportunity to make the beginning came through a grant to the National Council for Homemaker-Home Health Aide Services from the American Association of Retired Persons - National Retired Teachers Association.

It was also thought that an interpretation of costs for homemaker-home health aide services would be facilitated by a survey of comparative costs of alternative forms of service. This decision led to the problem of determining which alternative forms of service should be included in the survey.

Homemaker-home health aide service helps families to remain together in their own homes when health and/or social problems occur, or to return to their homes after specialized care. The homemaker-home health aide carries out assigned tasks in the family's place of residence, working under the supervision of a professional person who also assesses the need for the service and implements the plan of care. For comparative purposes, then, the forms of service alternative to homemaker-home health aide service which are used in the survey are those which involve personal services and household maintenance given by persons outside the family: hospitals, extended care facilities, nursing homes, residential treatment centers, foster homes, agency-operated group homes, and shelter care. Day care may be used concurrently

with the homemaker-home health aide services, so that the two complement each other, and are not necessarily alternative forms of care.

Survey method

The approach used to collect available cost information included the following:

1) A search for major reports, articles and studies of costs and cost savings for homemaker-home health aide services;

2) A search for major reports, articles and studies of costs and cost savings for the selected alternative forms of services;

3) Communication with other national agencies, such as the Child Welfare League of America and the American Hospital Association, to ascertain if they could provide national averages of costs for specific types of services as well as what is included in the costs, e.g., capital expenditures, overhead, administration, direct service costs, etc.;

4) Examination of letters, reports, and findings from other projects available in the files of the National Council.

The criteria used for collecting the information on costs included in this report were (1) that the cost data referred to homemaker-home health aide services or one of the selected alternative forms of service and (2) that the cost data were relatively recent, at least not published prior to 1968.

The inevitable problems

The lag between applicability of the cost data and the availability of a published report provided an inevitable and difficult problem for making comparisons of costs among the various forms of services. Only cost data applicable to the same time period, reflecting similar conditions and dollar value, were deemed comparable. Given the current trend of rapid inflation, comparison of today's costs of service in any one setting with 1968 costs in another setting, cannot really be made without serious distortion in drawing conclusions. There were also the problems of comparability in intensity and duration of service which could have marked influences on cost.

Other factors, such as geographic location of the agency or institution, that also vary and influence costs, created problems of comparability. In order to minimize such problems, it was decided that rather than using a formula for trying to make data comparable (as for example, increasing costs from other

years by a percentage close to the increase in cost of living), the year, and applicable locations of the data would be reported whenever possible.

Most trying of all the problems, the reports rarely stated what was included or excluded in arriving at costs. For example, often it is not stated whether organizations include initial capital costs, or the costs of maintaining and replacing major equipment. Most cost reports reviewed omitted some of the professional costs involved, e.g., those services provided by a public welfare department or other placement and supervisory agency, or the services of other agencies involved in a given case. Physician's fees were also found to be omitted from reported analyses of bed costs.

Uniform accounting and reporting systems have been developed for a few types of service, such as day care for children. This is very helpful, but even if all of the groups of like agencies had developed such systems, there would be difficulties in comparison of costs of alternative forms of service, which would not have comparable inclusions and exclusions.

For the purposes of this survey, it was decided there is no scientific way around the problems of unclear and unlike ways of cost accounting; the only way to handle them is to be as explicit as possible and suggest some conclusions, but let the reader make his own judgments.

Characteristics of Available Reports on Costs of Homemaker-Home Health Aide Services

Reports focused on age and auspice

A first, and not unanticipated, discovery in the survey was that reports of research were usually focused on either the elderly or on children, not both, although many agencies serve both. Moreover, the distribution between reports on in-home service to the elderly and to children was unequal. Homemaker service was initiated, historically, for in-home care of children. However, primarily because of the greater availability of government funding for in-home care of the aged, a greater portion of the service is now used for the elderly. Another reason for the greater increase of in-home care for the elderly compared with such services for children is that the costs of hospital and other institutional care, which are the community's usual ways of caring for elderly people dependent on it, have risen so rapidly that program administrators and third-party payers are under pressure to look at alternative forms of care. Foster family care, the community's usual way of caring for children dependent on it, is less alarmingly expensive at first glance. Another reason that services to the elderly have come into prominence is that the proportion of elderly persons in the total population, and the actual numbers of older persons,

have grown dramatically. This same divergence in focus of service is reflected in reports of costs of services; at present there are more studies and articles on costs, savings, and humanitarian benefits dealing with in-home service to the aged than with in-home service to children.

Homemaker-home health aide services also tends to be segmented by financial source - either health or social welfare. This is a false dichotomy, for not only are health and social needs inextricably related for the individual recipients of the services, but agencies in all settings serve individuals with a wide range of problems, so that the services for physical health and mental health, including those problems caused by social situations, might appropriately be considered together.

Reports on costs of homemaker-home health aide service inadequate

Another discovery was that reports, especially of research, on homemaker-home health aide service, are fragmented and limited. Single agencies and some multiple entity programs, such as state agencies, generate statistics on costs and benefits; however, such statistics are so diverse that there is little or no basis for comparability. Moreover, no data based on longitudinal (more than a year's time span) studies of persons served in relation to costs and outcomes of service were found.

Historical acceptance of out-of-home care

Foster care for children and institutional care of the aged are the forms of public care traditionally accepted by society. Articles about foster and institutional care generally do not advocate this form of service; advocacy is not seen as necessary. Descriptions of experimental programs or statistical reports covering number in care and per diem costs, particularly of institutional care, were found more often. In contrast, articles describing forms of in-home care, such as homemaker-home health aide services, and justifying their existence, seem to appear more frequently than those describing or justifying out-of-home care.

Institutionalization of the old, the physically disabled or the needy, and foster care for children have strong roots in the past. Only recently have poorhouses or "homes" stopped accepting people whose only problem is that they need financial support by society. If they need some physical care as well as financial support, the solution is still, normally, out-of-home care, except that recently, with the assistance of Social Security, Medicare and Medicaid, more persons are able to avoid prolonged institutionalization. The first major breakthroughs in the old patterns of removing persons who were economically dependent on society from their homes came with Social Security and medical assistance.

Under the surface of arguments for institutionalization is the fear that in-home care may invite wholesale use. Most people want to live at home as long as possible, and some will go to great lengths, suffering extreme deprivation, to avoid institutionalization. Those who are paying for services have a right to protect themselves from being overwhelmed with applications for service not really needed, but this is properly done through setting appropriate terms of eligibility for the service. However, the terms of eligibility should not be so stringent that those in genuine need cannot qualify or that the conditions of accepting service are so demeaning and painful that those who need it do without.

Perhaps because institutionalization as the primary setting for service has been so long accepted by the public, the real monetary costs of such care have not been questioned very deeply. The capital costs, the maintenance costs, and the administrative costs of keeping the system going have been accepted routinely. Also, there is undoubtedly an underlying belief that the larger the group served together, the smaller the cost per person. That this is not necessarily true will be discussed in the next chapter.

Although the purpose of this survey was to consider questions of cost, cost factors in terms of care of people should never be considered without concern for human values. A welfare department which lets out bids to homemaker-home health aide services, contracting with the lowest bidder without regard for whether or not it lacks basic standards, is removed in time, but not in spirit, from the city fathers in Charles Dickens' time who farmed out children to the homes which contracted to feed and house them most cheaply.

A society concerned for the welfare of its people must not sanction care provided without accountability. The federal government in 1973, in its efforts to remove the mandate for basic national standards in homemaker-home health aide services, was in danger of opening the door to economies in just those areas - training and supervision - through which agencies provide accountability for the people they serve. The elderly, the very young, the ill, and the disabled are always vulnerable.

The bibliographies at the end of this report are fundamental to it. Limited in coverage, in comparability, and in research bases; nevertheless, the materials in the bibliography document over and over again that many people in many sectors of our national life are concerned about developing viable alternatives to institutionalization and other out-of-home care for adults and children. Homemaker-home health aide service, the particular focus of this study, is an important component of in-home service in both health-based and social welfare-based care.

III

SURVEY RESULTS: COSTS OF SERVICES

Need - service delivery alternatives chart

A chart was devised for presenting the material obtained in an orderly way. It is based upon alternative settings through which services may be delivered to meet needs. In the information that follows, all cost data obtained during the survey are reported according to this design.

The nature of service rendered should be directly related to the physical and social needs which cannot be met by the individual alone or by the individual with the support of family or friends.[1] Usually the more intensive and/or extensive the care the more expensive the care. Service from the health and welfare systems which exceeds the needs of the individual or family, and that which does not meet the needs, results in inefficient use of money and inappropriate service to people.

Evidence attesting to such inefficiency is provided by a federal report which states that about 25 percent of the patient population are treated in facilities which provide more services than they need. The health care system is oriented primarily toward treatment of the acute phase of illness and does not offer a complete spectrum of health care by making alternatives to acute care available.[2]

This estimate may be conservative. A research report to the Essex County Council in England classified 464 elderly applicants for residential homes as to their capacity in five areas: sensory perception, intellectual processes, personal care, physical mobility, and domestic duties. It was found that 28 percent of the applicants experienced slight or no incapacity, while a further 23 percent were only moderately incapacitated. This would indicate that well over half the sample were applying for a facility offering more care than they

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[1]These ideas were suggested by Claire F. Ryder, M.D., M.P.H., Chief, Ambulatory and Home Health Section, Division of Long Term Care, Health Resources Administration.

[2]Study of Health Facilities Construction Costs, Report to the Congress by the Comptroller General of the United States, GAO Report, November 28, 1972, p. 10.

needed.[1]

The New York State Department of Mental Hygiene estimated that of the "8,000 elderly persons admitted annually to state hospitals (3,350 from New York City), at least 50 percent could be better cared for in the community" if appropriate programs were available.[2] In a Florida study, physicians and social workers estimated that 16-18 percent of the patients admitted to nursing homes in one county in one month could have had admission postponed, if in-home services had been available, while registered nurses put the estimated figure higher - at 30 percent.[3]

Inappropriate care is not only wasteful of financial resources, but the effects on the individual also can be negative, to the point of pushing him prematurely into a condition of even greater dependence. The elderly person living at home has a greater opportunity to exercise his physical and mental strengths. This can help him to retain independence and self-respect and to slow the rate of deterioration; in some cases, actually to eliminate altogether the need for complete care.

On the other hand, there is some documentation to substantiate that lack of needed care can be costly in both monetary and human terms. A one year study conducted by the Benjamin Rose Institute in Cleveland, based on 50 elderly patients who received home aide service after hospitalization and 50 who received no such service after hospitalization, indicates that the service group had significantly fewer days in and significantly fewer admissions to long-term institutions. They also appeared to be significantly more contented.[4]

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[1]R. Wager, Care of the Elderly - an Exercise in Cost Benefit Analysis Commissioned by Essex County Council (London: The Institute of Municipal Treasurers and Accountants, 1972).

[2]Community Service Society of New York, The Elderly and the State Mental Hospital in New York State (New York: Community Service Society, September 1969), p. 4.

[3]William G. Bell, Community Care for the Elderly: An Alternative to Institutionalization for Functionally Impaired Low Income Persons in Florida (Tallahassee, Florida: The Florida State University, 1971), p. viii.

[4]Margaret Neilsen and others, "Older Persons After Hospitalization: A Controlled Study of Home Aide Service," American Journal of Public Health, Vol. 62, No. 8 (August 1972), pp. 1094-1101.

Without studies conducted under a rigorous research design, it is very difficult to tell which is cause and which is effect: poverty, old age or poor health. The existence of an interrelationship among these three factors has been well documented through the National Health Survey.[1]

Once a home is broken, it is often difficult to repair. It is harder to move a person in and out of an institution than to move a homemaker-home health aide in and out of a home. Some forms of service, such as nursing home care or foster care, are less easily reversed or terminated than others. This feature tends to perpetuate the expense to society. Patients are often, if not usually, placed in nursing homes with the expectation that they will live out their lives there. A similar pattern exists in foster care of children where, all too often, out-of-home placement becomes subsidized care extending to adulthood. Shirley Jenkins reported that of 891 New York City children (excluding infants) placed in foster care in one year, about half were still in foster care after three months and one-fourth after two years.[2]

Three need factors

In order to compare costs of service appropriate to given needs, clusters were formulated based on three need factors: (1) need for environmental service, (2) need for personal service, and (3) need for professional service.

Environmental service involves basically the same housekeeping tasks in relation to all clusters of need and in all kinds of housing, whether home, hospital, or other institution. Clean, decent surroundings, and the provision of food and supplies for everyday living are necessary to health and survival. The individual living at home may be able to take the responsibility for more housekeeping tasks than one living in an institution, where procedures must be routinized; otherwise, cleaning and other housekeeping duties are not much differentiated according to where the individual is living.

Personal care has specific meaning under Medicare regulations. It covers

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[1]Forrest E. Linder, "The Health of the American People," Scientific American, Vol. 214, No. 6 (June 1966), pp. 21-29.

[2]Shirley Jenkins, "Duration of Foster Care: Some Relevant Antecedent Variables," Child Welfare, Vol. XLVI, No. 8 (October 1967), p. 451.

"bathing, toileting, assistance with ambulation, helping with prescribed exercises and medication" as well as performing household services necessary to the patient's health care. The definition of personal services used in this report is the one more generally used in everyday conversation, including all of the tasks in the Medicare description, but separating out household tasks except for feeding (as differentiated from preparation and serving of meals). To this list of personal services might be added such items as physical supervision, as of small children at play, or of elderly people whose movements are unsure.

The teaching and relating-to aspects of service, for example, helping a child with his homework, reading to him, handling a sibling battle, or helping an elderly person handle the crises of loss of physical abilities or death of a marital partner are difficult to fit into this framework. However, because they require careful professional supervision they will, in the context of this report, be considered personal services.

To summarize, those non-professional services provided for the physical and mental well-being of the individual, except for housecleaning and household tasks, are defined here as "personal service."

Housecleaning and other home management tasks, such as cooking and shopping for food, are defined here as "environmental service."

Also included in the concept of "environmental service" are informal contacts, such as the telephone reassurance, and friendly visitor services, which are designed to handle loneliness and social isolation. Provision of these services can entail minimal amounts of training and supervision. Actually, any and all of the human contacts by professionals, paraprofessionals, and volunteers, can help to meet social needs.

Personal and environmental needs are common to every human being; the issue is whether he is self-sufficient in meeting them. A further dimension is added by professional service needs, which might be said to stem from lack of normal functioning in some area or areas of the self, making care by a health or welfare professional necessary. Although the need for intermittent care by physicians and other professional persons is common to nearly everyone, the need for direct, regular professional care implies greater vulnerability to and dependency on others.

The inputs in environmental, personal, and professional services contribute directly to cost. A rough diagram which clusters need, complemented by in-home and alternative out-of-home services, has been constructed to show how the three factors may be related to setting.

The purpose of this study was to examine ways of serving people, and, if possible, to document the belief that even very good home care is usually less expensive than institutionalization or foster care.

Note: As the chart is stated, homemaker-home health aide services and out-of-home services appear as service delivery alternatives and are so described throughout the report. This is in relation to the current situation in which service is imprecisely fitted to the needs and wishes of the individual, partly because of the lack of availability of in-home care programs and partly because of the nature of the restrictions on funding by third-party payers. Used appropriately, however, in-home and out-of-home care generally are not alternatives to each other but meet different constellations of need. None of the forms of service delivery described in this report could or should be eliminated. Their use should be based on a plan of care developed from an assessment of the situation and of the preferences of the individual and his family.

NEED - SERVICE DELIVERY ALTERNATIVES CHART

NEED FOR SERVICE	SERVICE DELIVERY ALTERNATIVES*	
Professional, Personal and Environmental Service Needs	Homemaker-Home Health Aide Services	Alternative Out-of-Home Services
Cluster I: Need for professional and personal and/or environmental services (Professional assessment of need for service should occur in each situation in clusters I, II, and III.)	Homemaker-home health aide personnel function in the home as part of a health and social service team (The homemaker-home health aide in all situations in clusters I, II, and III should be trained and supervised.) (Intensity, duration, and specific tasks of the homemaker-home health aide service vary according to situation, not according to cluster.)	a) i. hospitals or extended care facilities for children and adults ii. nursing home care for adults b) i. residential treatment centers for children ii. foster homes, agency-operated group homes, and institutions for dependent children
Cluster II: Need for personal and environmental or personal services only	Homemaker-home health aide services provided in the home to cover the hours that the responsible person is absent, or to carry out particular tasks the individual is unable to perform for himself	a) shelter care or emergency foster homes for children and similar services, where available, for adults b) group day care for children and adults (Nursing home or other institutional entry may occur inappropriately at this point.)
Cluster III: Need for environmental services only	Homemaker-home health aide and/or chore services, meals-on-wheels, telephone reassurance, and other supportive services provided in the home by homemaker-home health aide and other agencies	(Nursing home or other institutional entry may occur inappropriately at this point.)

*see note preceding page

Cluster I:

In cluster I, the differentiating factor is the requirement for professional treatment, as distinguished from professional assessment of the situation and supervision of the paraprofessional. Although any human being may need professional treatment occasionally, the individual in cluster I is sufficiently out-of-normal balance in physical or mental health, or his physical or mental health is deteriorating, so that he requires regular, direct professional treatment and ready access to professional help. Individual needs in cluster I will vary greatly. The patient who has been acutely ill and is convalescing may need professional care on a daily basis from a doctor, nurse or social worker; the child in foster care may need only monthly visits from a social worker.

Environmental and personal services are needed by an individual in the first cluster but some elements of his care may be provided by his family, or, in the case of adults by the individual himself. If only professional care is needed, a person might require health services given at home but not those which a homemaker-home health aide provides. Then his need would not appropriately appear on a scheme related to homemaker-home health aide and alternative forms of service. It is possible for a patient to need only personal service to support the professional service. This might involve the homemaker-home health aide in changing dressings, or in giving baths, although it is likely in such situations that the bed linens will also be changed, and some other housekeeping details attended to in conjunction with personal service. It is also possible that personal service can be managed in the home by the patient or his family and that only environmental care is needed to support professional home health care.

It is much easier to adjust, in a flexible manner, the service which is given to that which is actually needed when care is provided in the home rather than in out-of-home settings. In the latter case, basic environmental service is always provided, and personal service must be provided or be immediately available.

In summary, homemaker-home health aide personnel in cluster I are part of a team of service-givers. The homemaker-home health aide's role is usually pivotal, however, for without it (unless the family can provide the necessary service), the individual must be cared for in an institution, where professional, personal, and environmental services are all available.

Cluster II:

In cluster II, personal service is required. The individual is not in need of regular direct professional treatment, but his age, condition or family situation are such that he needs help from someone outside the family in bathing,

feeding, dressing, and so forth. Any one or any combination of personal services may be required. Need for personal service implies more vulnerability and the need for more training and supervision, more agency supports, and more specialized services than environmental service needs alone; this accounts for the relative position of the two factors in the chart. Young children cannot take responsibility for self-care; their needs would be classified into clusters I and II. Environmental service needs may be met by the individual or his family, so that the homemaker-home health aide in cluster II is needed only for personal tasks such as giving a bath or lifting a person. Alternatively, if the individual and the family are unable to meet environmental needs, they may be provided by the homemaker-home health aide.

Cluster III:

Cluster III is based on the premise that need for environmental services alone indicates a lesser degree of vulnerability of the person to be served than do the needs for professional and/or personal services. Therefore, reduced need for professional input by the agency is implied, although the agency is always ultimately responsible to the person served and to the public for the services it provides. It is responsible for the care with which it selects its service personnel, for the provision and quality of professional assessment and plan of care, for the adequacy of training for the services performed, and for the provision and quality of supervision and support to the givers and receivers of service.

Homemaker-home health aide service units usually provide a number of or cooperate with those providing supplementary services, some of which involve the use of volunteers. Among these environmental support services are telephone reassurance, hot meals, chore services, friendly visitors, transportation, shopping, escort service, and barbering and hairdressing. Supplementary services may be provided in any cluster in conjunction with homemaker-home health aide services, and in cluster III they may be all that is needed.

The three clusters of need as defined are not clearly exclusive of one another. A person's needs may change abruptly. In-home services can, quite readily, be varied as needed, while out-of-home care usually is less flexible. The flexibility of homemaker-home health aide services is a tremendous asset in delivery of services appropriate to meet needs. The homemaker-home health aide may provide the only direct service, or her presence can facilitate a number of health and welfare services required to maintain individuals in their own homes. In each case services can be varied in intensity - hours of service in a day and the number of days a week the service is provided; in complexity - the range of homemaker-home health aide tasks and of other health and welvare services; and in duration - the weeks or months comprising length of

time service is provided to a given person or family. Included in the concept of complexity is the fact that although the care provided by the homemaker-home health aide is care of the individual or the family and of the immediate environment, the specific tasks required to provide this care may differ from case to case and from agency to agency. It must be recognized that homemaker-home health aide services vary in intensity, duration, and complexity according to the individual situations of the persons and families served, rather than according to the clusters presented in the chart.

The analyses of out-of-home costs are described here according to setting. Intensity, duration, and complexity of services tend to differ among out-of-home settings, and to a lesser degree, within settings. Thus, within cluster I, hospital care is provided for the greatest professional, personal and environmental need. Extended care facilities are geared to lesser need, and foster homes and nursing homes, to still lesser need. The out-of-home services are discussed in diminishing order of the complexity of services provided in each cluster.

In addition to the variables of intensity, complexity, and duration, the quality of service is crucial. Comparison of poor service with good service will give false findings, whether the comparisons are between nursing homes providing poor service and homemaker-home health aide agencies providing good service, or between homemaker-home health aide agencies which do not and homemaker-home health aide agencies which do provide quality services.

Recognizing, from the standpoint of those served and of those who pay for service, the need for quality as a crucial element in homemaker-home health aide services, the field, through the National Council for Homemaker-Home Health Aide Services, Inc., established an approval (accreditation) program in 1972 for governmental and voluntary non-profit and for-profit agencies. Adherence to the 14 basic standards established for agencies providing homemaker-home health aide services is strongly encouraged. Widespread use has already been made of these basic standards as a model upon which to modify and shape agency practice.

By March 1974, 43 homemaker-home health aide service units had completed and presented to the National Council their documentation of compliance with the 14 basic standards and were granted certificates of approval. Although these units differ as to auspice, geographic location, primary type of service given, and age groups served, all are certified as meeting the basic standards.

Costs of homemaker-home health aide services

One source of cost figures for homemaker-home health aide services evolved

from records provided by the 43 programs approved by the National Council as meeting the basic standards. A summary of cost facts from the 43 programs indicated an average cost per hour, per family, for service, during fiscal 1971 in some cases and fiscal 1972 in others, to be $3.98 within a range from $2.09 to $7.50. The median cost per hour was $3.79. For 32 of the programs, for which data were available, the average number of hours in direct service per case was 121; the average cost per case $467.79 a year.

These cost figures are generalized. They were usually computed on the basis of total cost divided by total hours or cases, but the contributions to total cost varied from agency to agency. Some of the reported total costs included all travel costs, fringe benefits, and other administrative costs; some did not. Some of the reported total costs included professional treatment services provided to the individual or family over and above the professional component required in training and in supervision under the basic national standards of the National Council for Homemaker-Home Health Aide Services. However, there is a likelihood that the variations were random, and that consequently the averaging provides a fairly good representation of costs for the approved programs.

Sometimes an arbitrary minimum as to number of hours per visit is set. Thus an agency offering service at a higher cost per hour but gauging the service to the actual needs of the family may have a lower average charge per visit than an agency charging less per hour but with a minimum of, for example, four hours a visit. Similarly, agencies providing professional assessments of the family situation, and training and supervision of the homemaker-home health aide have been shown, in analyses of agencies in at least two cities, San Francisco and Washington, D.C., to have lower average case costs than agencies without those components. The professional monitoring assists in the appropriate allocation of services.

The charges for out-of-home care cover costs for living accommodations, but do not necessarily exclude continuing costs for living accommodations at home. Rent or house payments, as well as payments for utilities and such costs of maintaining a residence may continue for the family when one member is in an institution, or even if the home is unoccupied but out-of-home care is expected to be temporary. On the other hand, the community may pay all living costs for a person living at home. Costs of care in alternative settings for an individual must be evaluated on a case-by-case basis, but generally speaking, it might be said that instances in which institutional or foster care represents duplication of costs for living accommodations probably at least equal the numbers of instances in which it represents substitution of living accommodations.

As previously specified, cost data for this report were organized by the different clusters of need complemented by service delivery alternatives. This was

done in an attempt to achieve greater comparability.

Costs: Cluster I - Professional with personal and/or environmental care needed

At the highest need in cluster I, care is to the sick, and the alternatives to in-home care are hospitals or extended care facilities.

The National League for Nursing annually collects cost and charge data related to home care services to the sick. Included are nursing, physical therapy, and home health aide services. Their 1973 review (their figures, like the National Council's, represent fiscal 1972 and in some cases fiscal 1971) showed that the median hourly charge for home health aide services was $3.77, in a range, by category, from $2 - $2.19 to $8 and over an hour. This median for charges is very close to the National Council's median for costs of $3.79, imparting a reassuring sense of the reliability of both statistics. In the National League for Nursing's analysis by region, the Great Lakes region was shown to have the lowest median, $3.44 an hour, and the Western region to have the highest, $6.60 an hour. The median for the Mid-Altantic region was $3.60, and for the South, $4.25.

It is worth noting that the median charge for a nursing visit was $10.96 and for a physical therapy visit $12.58. Both costs and charges for nursing visits increased with size of agency.

The Home Care Association of Rochester and Monroe County, Inc., New York, in 1973 examined statistics on patients who received home care at an intensive level. Among the patients were six persons ranging in age from 8 to 61 who had leg fractures and who would have stayed in the hospital while they were in traction if coordinated home services had not been available. All of them required nursing care, and two required physical therapy, drugs, x-ray and social casework. The visiting health aide provided a mean of 31 visits per patient for the five persons requiring this service. Including all the services provided, the average total cost of home care for these six patients, administrative costs included, was $1,325. The report indicated that, by comparison, the savings of in-home care over hospital care averaged $4,590 per patient or a total of $27,543.

In its 1973 annual report, this agency, which provides service in the home only at the intensive level, reports that the average cost per day of home health services is $16.10. The per diem cost of hospitals in that community is $108.

The extent to which in-home care can be used appropriately when hospital care is not really necessary depends largely on what services of a supportive nature can be made available to the individual while at home; for example, those of a homemaker-home health aide; a public health nurse; a physician who will make

house calls or to whom the ill person can be transported; occupational and physical therapists and so forth. Availability of the necessary and appropriate in-home services can help the person stay at home, thus preventing intensive hospital care, or it can facilitate his return home more quickly from the hospital. For the most intense and extensive need, in-home care is by no means always an answer; however, based on proper assessment, it can be used appropriately without sacrificing quality of service to eliminate, in part or in whole, an inappropriate stay in the hospital. Large scale economy in dollars saved can result.

A problem is caused by the funding mechanisms of Medicare and other third-party payers which place limitations on the tasks a homemaker-home health aide may carry out in a home where there is a health-related problem. Sometimes two agencies must become involved in these cases, one supervising a "homemaker" and the other supervising a "home health aide" to carry out related personal and environmental services which could be accomplished by one paraprofessional with economic and humanitarian gains. In other situations in which the second paraprofessional is unavailable, the patient may be forced to stay in a medical care facility.

Costs of hospital care.--The national median cost per day in July 1973, of a hospital stay, was $94.93, and was estimated to have increased to $99.93 by the end of the year. The average length of stay was 7 days, at a cost of $667.08.[1] The cost in some hospitals was considerably higher. The national median per diem in-patient hospital revenue per patient in teaching hospitals for the six-month period ending June 20, 1972, was $125.77. In-patient revenue in children's hospitals averaged $132.60 a day.[2] The direct cost of housekeeping alone, excluding meals and laundry, ranged from $92.81 to $142.36 per 1,000 feet per month. The cost per 1,000 feet rose with size of hospital. In September 1973, Secretary of Health, Education, and Welfare, Caspar W. Weinberger, was quoted as saying that the average daily charge for a hospital room was, in some places, $145.[3] These figures exclude physician's bills, ambulance costs, care of family members left at home, etc.

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[1]Carol Brierly, "Hospital Costs: What the Figures Really Say," Prism: The Socioeconomic Magazine of the American Medical Association (February 1974), pp. 12ff.

[2]American Hospital Association, Six-Month National Comparison for Period Ending June 30, 1972. (Chicago: American Hospital Association, 1972), pp. 8, 43.

[3]Bureau of Community Health Services Information - Public Health Service, Health Services Administration, Bulletin #1 (September 1973), p. 3.

In spite of the obvious savings of in-home care over hospital care, the curious convolutions of some third-party payer regulations may make it necessary for the patient to go to the hospital in order to become eligible for covered home care. And, in fact, hospital care is the only form of care covered by some third-party payers, so that the patient must be in the hospital to receive the care for which he is insured. Furthermore, during fiscal year 1971, only .8 percent of the total medical insurance claims paid under Medicare were for home health services.[1] The amount of money used for homemaker-home health aide service would be a tiny fraction of .8 percent.

An interesting finding in costs according to size of hospital is reported in a study of community hospitals (fiscal year 1962 to fiscal year 1966):

> "hospital expenses per day of hospital care increase uniformly with bed size...More surprising than the tendency for larger hospitals to have higher costs is the more rapid rate of increase of expenses in larger hospitals."[2]

Substantiation of this finding was also found in statistics compiled by the American Hospital Association. Expenses per adjusted in-patient day for community hospitals for 1970 and 1971 were found to rise as the size of the hospital rose from 25 beds to 500 and over. A more rapid increase in proportional expenditures appeared to occur at about 200 beds.[3]

Possible reasons for increase in cost as size of hospital increases suggested by the researchers are that the larger hospitals have greater utilization, greater number and variety of services, more sophisticated equipment and technology, are located in large metropolitan areas, admit more difficult cases, tend to be public hospitals.[4] Moreover, it is possible that the handling of many patients by many employees can become administratively cumbersome, complex, and cost-inefficient.

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[1] Fifth Annual Report on Medicare for Fiscal Year 1971, #87-6790, (Washington: U.S. Government Printing Office, 1971).

[2] Karen Davis and Richard W. Foster, Community Hospitals: Inflation in the Pre-Medicare Period. (Washington: U.S. Department of Health, Education, and Welfare, 1972).

[3] American Hospital Association, Hospital Statistics, 1971, pp. 8, 9.

[4] American Hospital Association, p. 8; Davis and Foster, pp. 16, 17.

A pertinent finding emerges, too, in ratios of employees to patients in hospitals. The American Hospital Association reported a ratio in 1971 of 209 full-time equivalent personnel per 100 average daily patient census - or two employees to a patient. This figure excluded trainees (student nurses, interns and residents), private duty nurses, and volunteers.[1]

Noteworthy as an illustration that services which do not appropriately meet the needs of the individual served tend to be the most expensive in the long run is a study conducted by the Rand Institute for the Health Services Administration. The major findings of this study was that the most costly rooms were the ones handling the most non-emergency cases. Moreover, according to the report, it was discovered that hospitals did not have an accurate idea of what staffing and operations really cost, that published figures for hospitals underestimated the cost of every patient visit, and that costs varied from hospital to hospital by as much as 60 percent.[2]

Costs of extended care facilities.--Extended care facilities, which either may be in a hospital or separate from it, generally house patients who have passed the critical stage of an illness. The American Hospital Association reported a median operating expense per patient day of $13.47 to $19.05 in 1972 for care in nursing or extended care facilities.[3]

Costs of nursing home care for adults.--In nursing home care for adults (as in foster homes, agency-operated group homes and institutions for dependent children in the following sub-section), professional care and treatment are necessary but on a less intensive basis than in a hospital or residential treatment center. Much of the care is given by paraprofessionals. The need in these subcategories of cluster I is less intense than in the preceding ones, but it is more often of long-term duration and for this reason, costly.

A much-used statistic showing that only 4 to 5 percent of the nation's over-65 population are in nursing homes and extended care facilities is misleading, because it is based on cross-sectional rather than longitudinal data. The percentage of the over-65 population in a nursing home or extended care facility at any

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[1]American Hospital Association, Hospital Statistics, 1971, pp. 2, 6.

[2]The New York City Rand Institute, Year 3: A Report to the People of the City of New York (New York: The Rand Institute, 1973), p. 24.

[3]The American Hospital Association, Six-Month National Comparison for Period Ending June 30, 1972, p. 46.

one time is not the same as the percentage of the over-65 population which will become institutionalized before they die. Indications that a much larger portion of the population reaching old age will become institutionalized were found by Dr. Robert Kastenbaum, of the University of Massachusetts, and Mrs. Sarah E. Candy, of Wayne State University, who examined death certificates filed in Detroit during 1971. Of those referring to deaths over age 65, 20 percent occurred in nursing homes. If the tabulation were broadened to include all extended care facilities, one aged person in four was found to have died in an extended care facility. Residents of nursing homes and other extended care facilities, of course, often do not die there but are transferred out for medical reasons and die in a hospital.[1] A finding corroborating Kastenbaum's was that in an analysis of deaths of persons 65 or over in 1969 in Pima County, Arizona, 19 percent occurred in nursing homes.[2] It is interesting to speculate how many persons who are now destined to live out their last years in congregate care facilities might spend those years in their own homes if home care services were provided by the community to supplement the capabilities of the persons and their families.

A number of reports were found that dealt with cost in providing homemaker-home health aide and related services to the elderly. The director of the nursing service of Cardinal Ritter Institute noted, "some patients are seen daily and some are seen only one time a month, depending upon the type of care needed by the patient," but she reported that the average number of all visits per case in a month was 4.6, at an average cost of $11.89 a visit, within a range of $10.53 per home-health aide visit to $32.85 per social service visit. The costs for nursing and physical, speech and occupational therapy visits varied between those of the homemaker-home health aide and social worker. The average cost per case per month was reported as $54.69. The average duration of care was reported as being 103.9 days, or about three months. Consequently, the average cost per case amounted to $185.95. However, it should be kept in mind that these figures include service to the elderly with differing intensity and complexity of needs.[3]

The director of the Home Care-Homemaker Service, Des Moines-Polk County,

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[1]"Institutionalized Aged: The 4 Percent Fallacy," Geriatric Focus, Vol. 12, No. 3 (March 1973), pp. 1, 5, 6.

[2]Billie J. Underwood, Final Evaluation of the Areawide Model Project on Aging (Tucson, Arizona: Pima Council on Aging, 1973), p. 43.

[3]Sister Ann Ambrose, The Cardinal Ritter Institute, St. Louis, Missouri: Letter to the National Council dated June 1973.

Iowa, made another point: "the service is utilized on an intermittent basis by many. In certain cases, there can be a period of several years between periods of use." At this Iowa agency, the number of hours of service per month per case averaged seven.[1] It might be noted that the Cardinal Ritter average of 4.6 visits per case per month included only visits by the social worker and the homemaker-home health aide, while the Iowa figure of 7 visits per month, included, in addition to the homemaker-home health aide service, nursing, casework, mobile meals, chore service, and other supplementary services.

From the data collected by the homemaker specialist in the Iowa State Department of Social Services, it was estimated that the average monthly cost in 1973 of this more comprehensive homemaker service to adults was $83, as compared to the Cardinal Ritter cost per month of $54.69. An analysis of homemaker service to 328 persons who might otherwise have been placed in nursing homes indicated that Iowa saved $71,039 in just one month.[2]

A survey in Clark County, Nevada, September 1, 1967, to August 31, 1969, disclosed an average of 303.5 hours of service per Old Age Assistance recipient over two years. Costs of homemaker service and welfare grants over two years to the 113 persons (102 cases) were totaled, and estimated savings over alternative forms of care appropriate to the individual served (group care, nursing home care, intermediate care facilities, and one hospital were included) equaled $93,613 for the two years.[3]

The New Jersey Department of Health reported that for services provided by 24 voluntary homemaker-home health aide agencies, the average number of homemaker-home health aide hours per patient was 152 for the year 1972, and the average cost per patient was $45.8. Each of the 10,843 persons served was diagnosed according to the International Classification of Diseases.[4] The New Jersey hour and cost figures are roughly comparable to those calculated from data given by the approved programs of the National Council for Homemaker-

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[1]Letter, Frances Shambaugh, Home-Care Homemaker Service, Des Moines-Polk County, to Nancy Robinson, September 4, 1973.

[2]Letter, Geneva Hawk, Iowa State Department of Social Services, to Frances Shambaugh, August 20, 1973.

[3]Letter and attached report, Stephanie Stephens, Community Services Branch, Administration on Aging, to Roberta Hunt, June 1970.

[4]Letter and attached report, Herbert B. Denton, State of New Jersey Department of Health, to Nancy Robinson, June 1973.

Home Health Aide Services and by the National League for Nursing. It might be noted that there are other homemaker-home health aide agencies in the United States which use the International Classification of Diseases.

Costs of nursing home care.--Data from the National Health Survey were collected in the summer of 1969. According to this report, the average monthly charge of nursing homes for intensive nursing care was $373, for limited nursing care $335, for personal care facilities $276, and for facilities offering no nursing or personal care $219.[1] These figures are probably far below charges and costs now, four or five years later, after a protracted period of rapid inflation.

More nearly current statistics were obtained from a Maryland report.[2] Because this report is recent and because its findings should have considerable impact on policies for the care of the elderly persons, some background to the report follows.

In 1970, thirty-six elderly persons died as a result of Salmonellosis in one Maryland nursing home. Subsequently, Governor Mandel ordered creation of a commission to investigate nursing homes and other forms of long-term care.

Maryland has (1) chronic illness nursing hospitals, to care for persons with terminal conditions, intractable pain, and others in need of continuous nursing service by an RN or by an LPN under the supervision of an RN; (2) skilled nursing care facilities for those who need observation and treatment under the supervision of an RN and may need physical or other therapy; and (3) intermediate care facilities for patients for whom most needs can be met by non-licensed personnel. The average cost for care of the chronically ill over a two-month period in 1972, per patient day, at one of the hospitals was $38.71. This figure apparently excludes all capital costs, including only salaries, food, insurance, utilities supplies and equipment. Costs of doctor's visits, drugs, laboratory tests, etc., were also excluded. For skilled care, on the same base, the cost per patient day was $31.52, and for intermediate care $23.72.

Although there are definitions of skilled and intermediate care, the individuals classified under these terms vary greatly in amount of care needed. The cost

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[1]United States Department of Health, Education, and Welfare, Public Health Service, Charges for Care and Sources of Payment for Residents in Nursing Homes, United States - June-August 1969, DHEW Publication No. (HRA) 74-1706 (Washington, D.C. U.S. Government Printing Office, 1973).

[2]Report of the Governor's Commission on Nursing Homes (Baltimore: Governor's Commission on Nursing Homes, 1973).

figures in the Maryland report were also broken down according to the self-care abilities of the individuals: self-care--$9.11; minimum care--$15.74; intermediate care--$26.13; maximum care--$48.52 a day.

Maryland pays for all intermediate care patients at $17 a day, for all skilled nursing care patients at $18 a day, for chronic nursing care patients at $30 a day. Since along the entire continuum of care there are savings in cost for nursing homes by their selection of patients best able to care for themselves, and there is a shortage of chronic care beds, those with need for chronic care may be unable to obtain it, and must accept what service they can get. The Maryland report stated "chronic patients then end up in skilled nursing homes (the attending physician can authorize this), where they receive inadequate care for their needs and often quickly die."[1] Meantime, those with lesser degrees of need for care are in facilities offering more care than they need.

Maryland's Old Age Assistance payments are $96 a month. Special allowances for home care are permitted for long-term, intermediate care (Level A) of a maximum of $210 a month or for personal, intermediate care (Level B) of $150, or for domiciliary care of $110, or for housekeeping or personal services in a person's own home (rather than intermediate or domiciliary care outside his home), up to $80 monthly. A foster family may receive $150 a month to provide a home for an adult. The Supplemental Insurance Income benefit payments, operational as of January 1, 1974, provide $130 per month to a needy adult.[2] As usual, support to persons at home is offered at a much lowel level than to the same persons out-of-home.

The Maryland study also revealed some patterns in nursing home ownership which can only be disturbing to those who believe care should be objectively determined and provided to fit the needs of the vulnerable elderly population. A large number of homes in Maryland are owned by three corporations controlled by about twenty-five individuals in all. A number of real estate corporations in Maryland exist solely to hold the real property for nursing homes. Many Maryland physicians and pharmacists have financial interests in nursing homes, a practice not discouraged by the present codes of ethics. The Governor's Commission on Nursing Homes has recommended that there be mandatory disclosure of all ownership interests in nursing homes.

The Florida Department of Health and Rehabilitation Services contracted for a study on alternatives to institutional care for the elderly.[3]

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[1]Report of the Governor's Commission, p. 215.

[2]Report of the Governor's Commission, p. 82.

[3]William G. Bell, Community Care for the Elderly: An Alternative to Institutionalization for Functionally Impaired Low-Income Older Persons in Florida (Tallahassee: The Florida State University, 1971).

Statements in the Florida report give further evidence of the disproportionate public support of institutional as compared to in-home services:

> In considering the range of medical and related health resources for the aging, there is evidence a growing imbalance exists in present approaches to serving elderly at home requiring long-term care. When comparing the range of service provided to the 31,000 elderly in nursing homes to the community services available to the 138,000 impaired elderly residing outside nursing homes, the difference in allocation of personnel and resources is striking. On the one hand a costly network of congregate facilities, health professionals, specialists and supportive personnel, endowed largely by public funds has been devised. By contrast, for a comparable group of unwell elderly in the community, four times the size of the institutional aged, there is yet to be established a stable system approaching in scope the institutional program...State planning is charged with focusing on the most vulnerable among the high risk groups requiring health service. To subsist in a period of extreme physical dependency brought on by chronic illness may be tolerable when supported by help from family members or close friends. However, to be aged, poor, impaired and dependent on public resources suggests a vulnerability of excessive dimensions.[1]

Perhaps the most significant statement is:

> As a consequence of national and state policies, the delivery of health care services to the impaired aging tends to favor the institutional mode, thus stimulating wide use of nursing homes for long-term care of low-income disabled elderly...Data...indicate a "scissor-effect" arises out of current practices. In reviewing expenditures over recent years, two concurrent opposing trends have come to light in separate facets of Florida's Old Age Assistance...caseload. A steadily increasing OAA patient load in nursing homes (as part of Medicaid) coincides with a steadily decreasing OAA caseload receiving direct assistance at home.[2]

One of the reasons institutional care is more widely accepted than in-home care

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[1]Bell, pp. 6, 7. [2]Bell, p. 7.

may be because of the commonly held assumption that the more people who are handled together in a single facility, the more inexpensive the unit cost of care. However, that this is not necessarily true was shown in the analysis of hospital costs indicating diminishing economy as hospitals grow in terms of number of beds. The relationship of size to cost in nursing homes is not clear. From the National Health Survey it was learned that "As the size of the homes increased, the average most frequent charge increased." It was speculated that charges for large homes were highest because most of them were nursing care homes, as distinguished from those smaller homes offering less of the professional nursing service. Nursing homes in the National Health Survey ranged in size from less than 25 beds to 100 beds or more.[1] In apparent contradiction to this finding, England's Essex County Council's study showed "although there is substantial variation in unit running costs within each size range, a clear relationship between size of home and unit cost is evidenced overall. The correlation coefficient--confirms the strong tendency for costs to decrease with (increase in) size of home within the range twenty to sixty-five places..."[2] A Massachusetts study also indicated declining costs with increase in size of nursing homes. The largest nursing home in the Massachusetts study had about 150 beds.[3] Further research relating cost to size, taking into account the standard of service given in the institutions analyzed, is needed.

The Essex County Council study was one in which both "unit capital costs" and "running costs" were analyzed. It is suggested in the report that estimates of the value of items not usually analyzed would be helpful. For example, in Great Britain the housing shortage is such that the author suggests that underoccupancy of single dwellings by elderly persons is of concern, that if small houses were made available to them, the larger accommodations would be released for optimum use. The writer of the foreword to the Essex County study suggests that there should be costing of such items as voluntary services: "Since there is a shortage of voluntary workers within the system, their use in any one activity does impose a cost (sacrifice) on the others, so they are not really a costless resource." This point was also subsequently made by William Pollak.[4]

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[1]Charges for Care in Nursing Homes: United States - April-September 1968. DHEW Publication No. (HSM) 72-1037 (Washington, D.C.: Government Printing Office), pp. 3,4.

[2]Wager, p. 45.

[3]Hirsch S. Ruchlin and Samuel Levey, "Nursing Home Cost Analysis: A Case Study." Inquiry, Vol. IX, No. 3 (September 1972), pp. 3-15.

[4]Costs of Alternative Care Settings for the Elderly (Washington, D.C.: The Urban Institute, 1973).

The complexities of including these kinds of facts in calculation of time-service costs can be enormous. It might be possible to establish the friendly visitor, telephone reassurance, and other supportive services to the homebound patient, or similar inputs to the institutionalized patient, but virtually impossible to assess the neighbor's or family's input as volunteer services. These "extras" may exist in either setting. For example, a patient's family may supplement nursing home care by paying for someone to bathe the patient daily or to provide supervisory or leisure time activities the nursing home lacks.

A major conclusion of the Essex County Council is "a greater 'return' would be obtained by the relative diversion of resources in the future away from the expansion of residential (out-of-home) facilities into a selective domiciliary (in-home) care programme for those in substantial need of support."

Foster family homes or private family boarding homes for the aged are used, but national statistics on this form of care were not found. A report from Maine states that in 1970:

> The cost of a boarding home is $165 to $200 a month, drastically below the $240 to $810 a month charged in intermediate or extended care facilities. Further stimulation of boarding and foster homes, either through remodeling of present private residences, or building of larger homes, would relieve the present overwhelming patient load on skilled care facilities.[1]

Costs of homemaker-home health aide services to disturbed children and adults. --Some disturbed or disabled children or adults requiring personal services, household support and professional treatment by health and social service professionals can be cared for at home, given an appropriate array of services. The homemaker-home health aide who is especially trained to provide personal services and household support can make it possible for the ill or troubled person to live at home, carrying on as normal a life as possible.

Experienced, mature homemaker-home health aides with special training and skills are being placed more and more frequently in homes where buildup of family problems threatens to lead to family break-up or other serious problems. For example, a disorganized mother or a mother who is simply overwhelmed may be helped to change the family patterns of working and relating. A teaching

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[1]Steps for Maine's Elderly (Augusta, Maine: Governor's Committee on Aging, 1970).

homemaker-home health aide works with the mother in close cooperation with a social worker and other appropriate members of a therapeutic team, to assist with and demonstrate new ways of coping with the demands being made upon her.

The situation precipitating the use of the teaching aspect of homemaker-home health aide service may cover any of a wide range of problems. One of these may be the presence in a home of a disturbed child for whom the alternative to in-home treatment would have been residential treatment, a very expensive form of care, which cannot act upon the root causes in the family of the child's disturbance.

The executive director of the Wiltwyck School for Boys, which has initiated a project using a teaching homemaker-home health aide (whom they call a homemaker/organizer) to prevent placement of children or hasten their return home from placement, presented a paper in 1972 in which he compared in-home and out-of-home care costs. The comparison provides illustrative cost data for this type of need:

> "It costs approximately $18,000 to keep a child in residential treatment facilities for a year. We estimate...that a homemaker/organizer will cost somewhere between $13,000 and $14,000 yearly, taking into account the supportive staff and structures needed.
>
> We estimate that a homemaker/organizer can work with between one and three families per year, with three to five children in each family. A comparison of the figures indicated clearly that the homemaker/organizer program is a less expensive service option than the others on a unit cost basis."[1]

Costs of residential treatment centers.--Robert Elkin reported in 1969 on the costs in 32 children's residential institutions. He classified institutions according to the components of program. Costs were included whether they were incurred by the agency or by a parent organization. Imputed costs were included for donated goods and services, but capital costs such as land, plant, equipment

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[1]T. George Silcott, "An Alternative to Placement of Children: The Homemaker/Organizer" (New York City: National Council for Homemaker-Home Health Aide Services, Inc., 1972).

purchase, repairs and replacements, and depreciation were excluded. The annual range of costs for the children's institutions in 1966-67, even with these major exclusions, was from $2,234 to $22,976 per child. [1] Institutional care does not, of course, come "cheaper by the dozen" for large families, as in-home care does.

Costs of homemaker-home health aide services to dependent and neglected children. --It has been demonstrated that homemaker-home health aide services with supporting professional services can prevent foster care. About ten years ago, Santa Clara, California, undertook to provide teaching homemakers to families which had been divided or were threatened with placement of one or more children in foster care. Fifty-nine such families with 299 children were provided with homemaker-home health aide services. As a result, only thirteen children had to be returned to or placed in foster care. The estimated monetary saving by such action was very large. Homemaker-home health aide salaries for the three years amounted to $53,292, whereas placement of even 100 of the children in foster care for more than one year would have cost, for board alone, at least $100,000.

Exploration into costs for 24-hour live-in homemaker-home health aide services revealed that many agencies do not provide it. Of the agencies which do provide the service, some charge a flat rate, and some charge at the hourly rate for anywhere from 14-18 hours. Minimum wage and hour laws, especially those requiring time-and-a-half for overtime have posed a problem. Three shifts of homemaker-home health aides have been used in some instances, but this is generally recognized as an impractical and unsatisfactory solution, especially from the standpoint of the family served. Twenty-four hour homemaker-home health aide service, even at the highest rates of well over $100 per day, is more economical than out-of-home care if the alternative is, for example, a day in the hospital, foster placement of more than one child, or if out-of-home care results in breakup of a family over a longer period of time than a homemaker-home health aide would have had to be in the home. The decision to place a child in a foster home because the alternative of 24-hour homemaker-home health aide service is more costly than a day of foster care is poor economy if, as frequently happens, the "day" of foster care extends to a childhood of days in foster care which could have been avoided by the use of

[1] Robert Elkin, Relating Program to Costs in Children's Residential Institutions (Washington, D.C.: The American University School of Government and Public Administration, 1969), pp. V-1-V-4.

a few days, weeks or months of homemaker-home health aide service intervention to hold the family together. From the perspective of the overall case, in the long run, placement in foster care would cost far more than the use of homemaker-home health aide service.

A new element in relation to care of dependent children has been introduced by the current adoption situation. With a shortage of babies for placement, agencies can, more easily than ever before, place older children in adoption. The practice of subsidizing adoptions has also made it easier to place children permanently. It would seem efficient to use homemaker service for short-term family emergencies, and work toward helping the family get back to normal as early as possible. Where it seems unlikely that a child can remain with his family because of intractable problems such as continuing neglect or abuse, as determined by professional assessment, supported by observations of the homemaker-home health aide, the agency could immediately begin to work toward adoption, before the child or children get too old and harder to place, and before they become emotionally damaged by a series of impermanent foster homes. Foster care would be used only when family disintegration was irreversible, but the children were too old or for other reasons impossible to place in adoption.

Costs of foster care for children--Foster care is a generic term which may include foster family placement, agency-operated group homes, as well as institutional care for dependent children. The problems in reports of foster home costs are lack of completeness and lack of information about what factors are included in arriving at cost. Grow and Smith reported:

> "We find that one of every ten agencies does not know whether the rates paid to foster parents actually cover the cost of care. When we add to this the finding that over half the agencies reported that their rates do not cover costs, but at the same time over half the agencies believe their rates are high enough to obtain and retain foster parents, a serious question must be raised. Are foster parents still viewed as service recipients, or at best, agency volunteers... ?...the findings suggest that agencies still do not see a relationship between adequate board rates and the recruitment and retention of good foster homes."[1]

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[1]Lucille J. Grow and Michael J. Smith, Board Rates for Foster Family Care (New York: Child Welfare League of America, 1970), pp. 23, 24.

From such a statement one might question the true cost of foster family care figures. Also, little attention is paid to the "shadow costs" of the extra expenses of the foster family itself, as well as the administrative expense of operating the agency.

Board payments to foster parents are only part of the cost of foster care. In November 1973, payment to foster parents in the New York City area was $155 a month, with additional payments made for clothing, haircuts, and other extras. The City, however, pays the child care agency furnishing and supervising the home approximately $12 a day, or $360 a month per child. In arriving at the cost required to provide foster care services for a family, the $360 must be multiplied by the number of children put into care from that family and also by the number of months each child remains in care. Moreover, there can be further subsidy from the voluntary agency. As can be seen, foster care can be an expensive service even without including the administrative costs of the City's Bureau of Child Welfare of the Department of Social Services, the agency legally responsible to the public for the care and financing of care for all public wards.

Fanshel and Shinn studied in detail the cost of foster care over a span of five years for 624 New York City children who entered care in 1966. Costs per child and per family are given in this study for a day's care, a four year period, and as projections by family until each child reaches maturity. Based on the actual four year cost, the authors calculated that a child entering the system in infancy and remaining in care until age eighteen would cost an estimated $112,500. In comparison to cost data for rearing a child in his own home, as published by Jean Pennock in Family Economics Review, December 1970, they state..."the cost of foster care appears to be about five times the expense a family on a low-cost budget would incur, in rearing its own child."[1]

Again, the estimates in this study do not include costs of operating the Bureau of Child Welfare as the public's administrative agent responsible for child welfare services for New York City children.

In New York City the average per diem reimbursement rate for fiscal 1972-73 from the state and city to voluntary child care institutions was about $30.50 per day per child, - $915 a month. In addition, agencies receive from $ .41 to $11 a day per child for Medicaid. Although the per diem rate for institutional care is approximately the same whether the child is in residential

[1]David Fanshel and Eugene B. Shinn, Dollars and Sense in the Foster Care of Children (New York: Child Welfare League of America), 1972.

treatment or cared for in an institution for neglected, dependent children, the Medicaid rate is greater if the child is in a treatment center.

Costs: Cluster II - personal and environmental services needed, or personal service needed

Cluster II, indicating need for personal services, sometimes combined with environmental care, presupposes lack of need for regular direct professional treatment. This may be because individual strengths or family supports normally are such that only temporary assistance from the community is necessary. Crisis intervention may be provided by professional persons supported by the paraprofessional homemaker-home health aide, with quick reintegration of the individual and the family. If the initial assessment leads to regular direct professional treatment, the individual moves into the cluster I category.

Children may be caught in a sudden crisis in which care must be provided for them at once: parents disappear overnight, abandoning the children; the single parent becomes ill; there is alleged abuse or neglect; parents are incarcerated. A homemaker-home health aide may be placed in the home while a social worker explores the situation. Then either the family takes over again quickly, or a longer-term plan of care (at cluster I) is designed.

Another example of cluster II need would be a situation in which the family is functioning adequately, but cannot care for the child or elderly person around the clock, so a trained, supervised homemaker-home health aide bridges the necessary hours.

Costs of personal and environmental care needed in crisis situations.--National figures on costs of emergency care to children were not found; but a fairly recent program analysis of care to neglected and dependent children[1] gave particular attention to shelter care. Nashville-Davidson County in Tennessee was the source of the data. Entry into the metropolitan child care system for neglected and delinquent children was through petitions filed by neighbors, welfare workers, parents, and others. If the children could not stay with their petitioners, they were normally placed in a child care institution pending court hearing two or three weeks later. As the report stated,

> This subjects the children to a traumatic experience when they are removed from their homes by strangers, frequently in the middle of the

[1]Marvin R. Burt and Louis H. Blair, Options for Improving the Care of Neglected and Dependent Children (Washington, D.C.: The Urban Institute, 1971).

> night. In these situations, the parents often appear within a few hours or are located the next day. However, once the children are placed..., it takes a court order to get them released, requiring several days and usually longer.

Options for improving the system were suggested and costs of the new programs estimated, e.g., twenty-four hour intake screening service which would cost $12,000 a year might eliminate up to 180 petitions a year (per child cost $67); emergency caretaker service (usually overnight custodial care) would cost $5,000 a year and keep 25-50 children a year at home (per child cost $100-$200); emergency foster family homes at a total cost of $18,000 annually would provide temporary care for about 70 children a year (per child cost $257); service by 30 homemakers would cost $219,000 and prevent 250 children from institutional placement (per child cost $876). Use of a mix of the four programs would reduce involvement of both the metropolitan police department and the courts, reduce placement of children in the institution, and save money.

This method of projecting costs for various program mixes is innovative. The conclusion of the study was that emergency foster family homes would be less expensive in short-term care of children than would homemaker service, but would be less effective, possibly resulting in more emotional trauma to the children. The researchers did not note the fact, documented by others, that emergency out-of-home care of children often becomes care to legal maturity.

Disabled adults and elderly persons incapable of caring fully for themselves and their immediate environments also may be thrown into a brief crisis situation by some termporary further disabling condition or by the temporary inability to care for them of those upon whom they are dependent. Shelter or emergency foster homes, which many communities have available for children, are less often available for adults so they may have to enter nursing home care at this juncture. For many reasons this emergency care for the elderly often becomes care until death.

Personal and environmental services during hours responsible members of family are working

The individual who needs personal and environmental services only when the members of his family are working may be less vulnerable than those without such family supports. It may be possible to reduce the amount of professional intervention, so long as the homemaker-home health aide is trained for the work she is doing and has enough supervision to provide professional support and accountability.

The individual who is largely able to care for himself and his home alone or

with the assistance of his family may require few hours of homemaker-home health aide service over a month's time, but at the same time may find those few hours crucial to prevent institutionalization. The position of the National Council for Homemaker-Home Health Aide Services is that although professional involvement may appropriately be minimal for these areas of need, accountability must always be provided for in-home service. Personal services must always be given by trained and supervised persons. For instance, the paraprofessional helping an infirm person to exercise needs guidelines for the task.

The alternative to home care for this area of need may be any of the out-of-home services discussed under cluster I. One form of service not yet discussed, but possible in this cluster, is group day care.

Costs of group day care.--Day care is not clearly an alternative to homemaker-home health aide service. With full availability of both options, the program could be used complementarily, based on assessed need.

A recent estimate of operational costs of child day care units placed the cost per child in a range from $1,553 to $2,656 a year.[1] Expenditure and income collected through uniform accounting procedures in the Chicago area showed average total cost per enrolled child for an hour of service to be $1.16 with a range of from $ .32 to $2.69.[2]

Reports on costs of day care for the elderly were not found.

Costs: Cluster III - only environmental services needed

The homemaker-home health aide may, in some instances, provide only environmental care, complementing the capabilities of the individual or family. For example, an elderly infirm couple may be able to meet each other's personal service needs and do some of the household tasks, but need a homemaker-home health aide to come in a few hours a week to handle tasks requiring more physical dexterity than either of them has. Care in this area may be provided by specialists or volunteers who render such supplementary services as meals-on-wheels, household repairs, chore or laundry service, escort

[1] A Design for a National Day Care Cost - Effectiveness Experiment (Ypsilanti, Michigan: High/Scope Educational Research Foundation, 1972), pp. 7-8-7-20.

[2] Day Care Utilization of Cost and Time Data (Chicago: Council for Community Services, 1972), p. 43.

service, shopping, transportation, barbering and hairdressing, and friendly visitors, alone or in conjunction with the homemaker-home health aide. Those providing environmental services may need minimum training and supervision, but the very young, the disabled, and the old, who are the recipients of in-home service, are vulnerable, and the agency must accept ultimate responsibility for the quality of care provided.

The cost per unit of service would vary according to the mix of paraprofessional and volunteer personnel, but in any case would be less than the cost of nursing care facilities. No form of institutional care could cost as little as a few hours a month of in-home care does.

Meal cost data were analyzed in a demonstration project in St. Petersburg, Florida. It was reported that in 1971 the total cost, including administrative costs, per delivered meal was $1.64.[1] A brochure from Onondaga County, New York, for 1972 listing agencies offering meal service notes charges of from $1 to $1.95 per delivered meal. Charges of under $2 seem to be typical of the agencies listed in the 1971 national directory of home delivered meals.[2]

Hadley Hall, executive director of the San Francisco Home Health Service testified to a Senate Subcommittee on Health of the Elderly,

> We have arrangements for physical, occupational, and speech therapy, and a large group of homemaker-home health aides. The average cost for a client for a month is about $158. This had held up for the last 2 1/2 years, though our costs have increased.
>
> One of the reasons for holding the line on the costs is that we have been able to add the meals-on-wheels program--we send in meals-on-wheels, say 3 days a week, and professionally supervised staff the other part of the time.[3]

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[1]Frederick Buchholtz, Home Delivered Meals for Older Americans-A Demonstration: Final Report and Guidelines - September 1971. DHEW Publication No. (SRS) 72-20234 (Washington, D.C.: U.S. Government Printing Office, 1971).

[2]Home Delivered Meals: A National Directory, SRS-AoA Publication No. 194 (Washington, D.C.: U.S. Government Printing Office, 1971).

[3]U.S., Congress, Senate, Special Committee on Aging, Barriers of Health Care for Older Americans, 93rd Cong., 1st Sess. 1973, pp. 387-388.

Out-of-home care is almost never appropriate to cluster III needs. Many elderly persons enter nursing care facilities, very much excessive to their needs, because their inability to get to the grocery store or to the doctor's office, or their relative's concern for their isolation in case of an emergency, has seemingly become an insurmountable problem. A daily telephone check (relatively inexpensive because volunteers are utilized and no transportation is involved), a "friendly visitor" who drops in regularly, someone to take the person to the store, or to give the house a weekly cleaning, or the provision of a hot meal delivered once a day, with interim assistance from a homemaker-home health aide, may prevent institutionalization temporarily or permanently, with not only substantial cost savings but also substantial human benefits.

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A cost analysis of homemaker services to adults in one county in one month. Preliminary to estimates of cost savings, selection was made of clients who would need alternate care or need to be placed outside the home within one month of discontinuation of homemaker services. Projected twelve months savings for the county through the use of two homemakers in lieu of boarding home, nursing home, intermediate, or attendant care, was about $48,000.

Brierly, Carol. "Hospital Costs: What the Figures Really Say." Prism: The Socioeconomic Magazine of the American Medical Association (February 1974), pp. 12ff.

An analysis of hospital costs citing 1973 costs, median length of stay, percent of occupancy, and describing one hospital's battle for financial solidity.

Burt, Marvin R. and Blair, Louis H. Options for Improving the Care of Neglected and Dependent Children, Nashville-Davidson, Tennessee: Program Analysis Applied to Local Government. Washington, D.C.: The Urban Institute, March 1971.

"The principal purpose of this study was to develop programs to improve the well-being of neglected and dependent children." Examined the existing system and offered options to the system. For each option (homemaker service included), costs and effectiveness were projected.

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This study was undertaken "to study the feasibility of a statewide plan providing alternatives to nursing home care." Recommendations included "legislation to facilitate the development and funding of the full spectrum of care; the encouragement of budgetary systems..." Cost figures are included.

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Maine Governor's Committee on Aging. Steps for Maine's Elderly. Augusta, Maine: Maine Committee on Aging, 1970.

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Recommendations for community care that would fit into the present reorganizational trends in the social welfare and health fields are cited. The Washington Bulletin is published by the Social Information Service.

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Discusses results of a 1971 study in Massachusetts which identified the "extent to which home health services are in fact provided to consumers, the projected cost of delivering such services"; quotes cost figures of nursing home care and homemaker service and the resulting savings by utilizing the latter.

_____, and staff. Alternatives to Nursing Home Care: A Proposal. A Report prepared for the Special Committee on Aging, United States Senate. 92nd Cong. 1st Session. Washington, D.C.: Government Printing Office, October 1971.

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